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May 10, 2021

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20420

Priority Open Recommendations: Department of Veterans Affairs

Dear Mr. Secretary:

As discussed in our recent meeting, the purpose of this letter is to provide an update on the overall status of the U.S. Department of Veterans Affairs' (VA) implementation of GAO's recommendations and to call your personal attention to areas where open recommendations should be given high priority.[1] In November 2020, we reported that on a government-wide basis, 77 percent of our recommendations made 4 years ago had been implemented.[2] As of May 2021, VA's implementation rate was 73 percent for these recommendations and VA had a total of 233 recommendations that had not been implemented. Implementing these recommendations could significantly improve agency operations.

Since our April 2020 letter identifying 33 priority recommendations, VA has implemented 13 of them. In doing so, VA improved care coordination, as well as its ability to ensure that veterans receive evidence-based mental health treatment. VA also took steps to collect complete and reliable information about employee misconduct and disciplinary actions, among other things.

We ask for your attention to the remaining 20 priority recommendations. We are also adding 8 new recommendations, including recommendations related to Coronavirus Disease 2019 (COVID-19) in state veterans homes, community care, succession planning, sexual harassment, on-campus veteran suicides, and supply chain management. This brings the total number of priority recommendations to 28. (See enclosure for the list of recommendations.)

The 28 priority recommendations fall into the following 12 major areas:

Response to the COVID-19 Pandemic.

Nursing home residents, who often are in frail health and living in close proximity, are at a particularly high risk of being infected with—and dying from—COVID-19. Although VA does not exercise supervision or control over the operation of state veterans homes, the department

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[1]Priority recommendations are those that GAO believes warrant priority attention from heads of key departments or agencies. They are highlighted because, upon implementation, they may significantly improve government operations, for example, by realizing large dollar savings; eliminating mismanagement, fraud, and abuse; or making progress toward addressing a high-risk or duplication issue.

[2]GAO, *Performance and Accountability Report: Fiscal Year 2020* GAO-21-4-SP (Washington, D.C.: Nov. 16, 2020).

provides oversight. In November 2020, we reported that VA does not collect timely data on the number of COVID-19 cases and deaths occurring in each state veterans home, hindering its ability to monitor the spread of COVID-19 in the homes and take steps to mitigate the spread of the virus and protect residents.

We have one priority recommendation from our November 2020 report to improve VA's response to COVID-19 in state veterans homes. We recommended that VA collect timely data on COVID-19 cases and deaths in each state veterans home.

To implement this recommendation, VA needs to demonstrate that it is collecting data from each of the 158 state veterans homes.

Veterans' Access to Timely Health Care.

Since 2012, we and others have expressed concerns about the Veterans Health Administration's (VHA) difficulties in providing timely access to care and effectively overseeing timely access to health care for veterans, including primary care.

We have two priority recommendations to improve VHA's oversight of veterans' access to timely health care. We recommended that VA

> (1) improve the reliability of wait-time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error; and

> (2) establish a comprehensive policy to define Veterans Integrated Service Network (VISN) roles and responsibilities for managing and overseeing medical centers.

Although VA has requested closure of our recommendation to improve the reliability of wait-time measures based on its completed actions, we continue to believe that additional actions are necessary. Specifically, VA's desired date field—intended to be the date on which the patient or provider wants the patient to be seen—is subject to interpretation, which poses concerns for the reliability of wait-time measures. Furthermore, VA's first internal audit, in February 2019, was unable to evaluate the accuracy and reliability of its wait-time data due to the lack of business rules for calculating these measures, indicating that additional efforts are needed to address this issue. According to VA officials, the department is in the process of implementing a new scheduling system for all VA health care facilities, with a targeted national completion date of 2027. Given our continued concerns about VA's ability to ensure the reliability of its wait-time data and the distant completion date of VA's new scheduling system, VA should clarify its existing policy or provide additional details and documentation regarding how the new scheduling system will address our concerns about wait-time data reliability.

Veterans Community Care Program.

Since its implementation in 2014, we and others have highlighted weaknesses in VHA's operation and oversight of the Choice Program, such as delays in scheduling appointments. In response to the VA MISSION Act of 2018, VA established a new Veterans Community Care

Program in 2019.[3] VA must ensure that veterans receive timely and quality care under this new program.

We have four priority recommendations to improve veterans' community care. We recommended that VA

(1) monitor female veterans' access to key sex-specific care services—mammography, maternity care, and gynecology—under community care contracts;

(2) establish an achievable wait-time goal that allows it to monitor whether veterans are receiving VA community care within time frames that are comparable to the amount of time they would otherwise wait to receive care at VA facilities;

(3) design an appointment scheduling process for community care that establishes time frames for processing, scheduling, and receiving care that are consistent with the wait-time goal VHA has established for the program; and

(4) align its monitoring metrics with the time frames established in the community care scheduling process.

Among other steps required to implement these recommendations, VHA needs to provide documentation that, as a part of its community care program, there is a monitoring plan to examine (1) timely appointment scheduling and completion times for gynecology, maternity care, and mammography services, and (2) driving times to these appointments and reasons appointments could not be scheduled with community providers.

Human Capital Management.

A strong workforce capable of providing quality and timely care to veterans is critical to the success of VA. Over the past two decades, we and others have expressed concern about certain VA human capital practices. For example, we reported in 2017 that VA did not maintain an accurate count of physicians providing care in the VA system, hindering its ability to ensure that it has the appropriate clinical workforce to meet the current and future needs of veterans. In particular, VA lacked data on the number of contract physicians providing care in VA medical centers because its personnel databases and workforce planning tools did not include contractors. We also reported in 2020 that VA has policies to prevent and address sexual harassment in the workplace, but some aspects of the policies and of the complaint processes may hinder those efforts. For example, VA's Equal Employment Opportunity (EEO) Director oversees both the EEO complaint process, which includes addressing sexual harassment complaints, and general personnel functions, which can create a conflict of interest.

We have five priority recommendations to improve VA's human capital management. We recommended that VA

(1) develop and implement a modern and effective performance management system in which VA managers make meaningful distinctions in employees' performance ratings;

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[3]VA MISSION Act of 2018, Pub. L. No. 115-182, tit. I, 132 Stat. 1393 (2018).

(2) develop and implement a process to accurately count all physicians providing care at each VA medical center, including physicians who are not employed by VHA;

(3) develop a department-wide succession plan for leadership and mission-critical occupations that incorporates key leading practices;

(4) realign VA's EEO Director position to adhere to an Equal Employment Opportunity Commission (EEOC) directive by ensuring the position is not responsible for personnel functions; and

(5) complete its EEO Program Manager realignment initiative in accordance with VA policy.

Although VA disagrees with our recommendation to develop a process to accurately count all physicians providing care at each VA medical center, we continue to believe that creating a system-wide process to collect information on all physicians providing care at VA medical centers, including physicians who are not employed by VA, is essential for accurate workforce planning. Additionally, VA needs to develop a succession plan for its leadership positions and mission-critical occupations, among other steps required to implement these recommendations.

Information Technology.

The use of information technology (IT) is crucial to helping VA effectively serve the nation's veterans, but over many years, VA has had difficulty managing its information systems and has faced challenges meeting data center optimization metrics. As a result, we and others have raised questions about the efficiency and effectiveness of VA's IT operations and its ability to deliver intended outcomes needed to help advance the department's mission. In addition, we have reported on VA's efforts to ensure cybersecurity, including issues with strengthening online identity verification processes and establishing risk management programs to address challenges.

We have four priority recommendations to improve VA's management of its information systems and data centers, as well as efforts to ensure cybersecurity. We recommended that VA

(1) improve its efforts to meet data center optimization metrics;

(2) develop a plan to discontinue using insecure, knowledge-based verification processes when performing identity verification;

(3) develop a cybersecurity risk management strategy; and

(4) establish a process for conducting an organization-wide cybersecurity risk assessment.

Among other steps required to implement these recommendations, VA needs to ensure its cybersecurity risk management strategy includes a statement of risk tolerance and describes how the agency intends to assess, respond to, and monitor cybersecurity risks.

Appeals Reform for Disability Benefits.

The Veterans Appeals Improvement and Modernization Act of 2017 required changes to VA's appeals process, giving veterans various options for having their claims reviewed.[4] In 2018, we reported that VA's plan for implementing a new disability appeals process did not explain how VA would assess the new process compared to the legacy process, and it did not fully address risks associated with implementing a new process. Since our March 2018 report, VA implemented appeals reform in February 2019. Nevertheless, many of the principles of sound planning practices that informed our recommendations remain relevant, even after implementation, to ensure the new process meets veterans' needs.

We have two priority recommendations to improve VA's disability benefit appeals process. We recommended that VA

> (1) clearly articulate in its appeals plan how it will monitor and assess the new appeals process compared to the legacy process, including specifying a balanced set of goals and measures and related baseline data; and

> (2) ensure that its appeals plan more fully addresses related risks prior to fully implementing the new appeals process.

Among the steps required to implement these recommendations, VA needs to establish a balanced set of performance goals and measures to assess how well the new appeals process is performing, such as measures of overall timeliness, accuracy, and veterans' satisfaction. VA also needs to assess risks associated with appeals reform against a balanced set of goals.

Quality of Care and Patient Safety.

In recent years, we have raised concerns about patient safety and the quality of care delivered in some VA medical centers. For example, in 2019, we found that VHA had not issued policies pertaining to employing providers who have had their Drug Enforcement Agency (DEA) registration for prescribing controlled substances revoked or surrendered for cause.

We have one priority recommendation to improve the quality and safety of health care delivered in VHA facilities. We recommended that VA develop policies and guidance regarding DEA registrations, including the circumstances in which waivers may be required.

Among the steps required to implement this recommendation, VA needs to develop policies regarding when a DEA employment waiver may be necessary and guidance about how VHA facilities should request such a waiver.

Veteran Suicide Prevention.

Under VA's 2018 National Strategy for Suicide Prevention, VA facilities are required to report information about on-campus suicides to VA's leadership through a variety of data sources, such as by conducting a root cause analysis when a veteran dies by suicide during or soon after receiving care at a VA medical facility. However, no single source of VA data provides a comprehensive count of these incidents, according to VHA officials. As a result, in 2020 we found that VHA does not have accurate information on how many veterans have died by suicide

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[4]Pub. L. No. 115-55, 131 Stat. 1105 (2017).

and its efforts to prevent future on-campus suicides is limited by its decision not to comprehensively analyze the issue.

We have two priority recommendations related to VA's efforts to prevent veteran suicide. We recommended that VA

(1) improve its process to accurately identify all on-campus veteran deaths by suicide; and

(2) expand the policy requirement for a root cause analysis to include all cases of on-campus veteran death by suicide.

Among the steps required to implement these recommendations, VHA needs to complete development of its process to collect accurate data for all on-campus veteran deaths by suicide and ensure that it uses updated information and corroborates information with all VA facilities.

VA Health Care System Efficiency.

It is critical that VHA closely monitor and account for how its funds are allocated to VA medical centers and redistributed throughout the year to help ensure the most efficient use of funds. In 2019, we found that certain funding allocation adjustments may not incentivize efficiency. For example, we found that some VISNs increased allocations to medical centers with decreasing or relatively flat workloads.

We have one priority recommendation to improve the efficient use of funds for delivering health care services. We recommended that VA revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workloads that received adjusted funding levels.

VHA has stated that it is conducting market assessments over a multi-year period, and after reviewing information resulting from these and other VHA efforts, it may consider adjusting the level of services along with other alternatives. To implement our recommendation, VHA must demonstrate it has taken these actions or otherwise must revise its guidance to require VISNs—in conjunction with medical centers—to develop approaches to improve efficiency at medical centers with declining workloads that received adjusted funding levels.

National Policy Documents.

To help carry out its mission of providing timely and high-quality health care to veterans, it is important that VHA develop and communicate national policies throughout the organization and ensure their appropriate implementation. Our work, along with that of the VA Office of Inspector General and others, has cited longstanding concerns about VA's oversight of its health care system, including concerns related to ambiguous policies and inconsistent processes, posing risks for veterans' access to health care and for the quality and safety of that care. At the national level, VHA has used a variety of document types to establish policy or to provide implementation guidance to its facilities. In September 2017, we issued a report on VHA's policy management and found that, contrary to its new national policy definitions, VHA continues to issue national policy through program office memos that lack vetting and are not subject to recertification. Recertification is the process by which VHA assesses whether a national policy document still serves a purpose and should be updated accordingly, or is no longer needed and should be rescinded or combined with another policy.

We have one priority recommendation to improve the development of national policy. We recommended that VHA further clarify when and for what purposes each national policy and guidance document type should be used, including whether guidance documents should be vetted and recertified.

To implement this recommendation, VHA needs to complete revisions to its national policy directive, which should clarify the use of national policy and guidance documents, as well as their recertification requirements.

Procurement Policies and Practices.

We reported shortcomings with VA's procurement policy framework and its management of certain procurement programs. For example, in January 2019, we reported that VA has not assessed duplication between its Medical Surgical Prime Vendor Next Generation program and its Federal Supply Schedule program. Most recently, in March 2021, we testified that the COVID-19 pandemic exposed problems in VA's supply chain management and highlighted the need for a comprehensive supply chain management strategy.

We have four priority recommendations to improve VA's contracting policies and practices. We recommended that VA

> (1) take steps to expedite completion of its updated acquisition regulation;
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> (2) document its strategy for its Medical Surgical Prime Vendor-Next Generation program and communicate this plan to all stakeholders;
>
> (3) assess duplication between its Medical Surgical Prime Vendor and Federal Supply Schedule programs; and
>
> (4) develop a comprehensive supply chain management strategy that outlines how VHA's various supply chain initiatives are related to each other and to VA-wide initiatives.

Among the steps to implement these recommendations, VA needs to issue the remaining sections of the revised acquisition regulation and develop a comprehensive supply chain management strategy that reflects key practices of organizational transformations, including an implementation plan with key milestones.

VA's Capital Planning.

VA provides medical services to a veteran population that is growing more diverse. These demographic shifts will drive changes in veterans' needs and expectations, and require adjustments to VA medical facilities. In June 2019, we reported that VA did not clearly instruct VA medical centers on how to meet the agency's strategic goal of incorporating veterans' changing needs and expectations into facility planning.

We have one priority recommendation to improve VA's capital planning. We recommended that VA instruct its medical centers on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as by identifying certain resources and tools and directing medical centers to use them.

To implement this recommendation, VA needs to provide guidance to its medical centers on incorporating veterans' input in facility planning.

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We believe implementing our 28 VA priority recommendations could result in more timely, high-quality care that our nation's veterans deserve. Furthermore, addressing the high priority recommendations has the potential to significantly improve VA's operations, including those related to COVID-19.

We also believe implementing our VA priority recommendations could be done in conjunction with efforts to address our High Risk List areas related to VA. In March 2021, we issued our biennial update to our High Risk List, which identifies government operations with greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.[5] Two of our high-risk areas— Managing Risks and Improving VA Health Care and VA Acquisition Management—center directly on VA. Three additional high risk areas—Improving and Modernizing Federal Disability Programs; Improving Federal Management of Programs that Serve Tribes and Their Members; and National Efforts to Prevent, Respond to, and Recover from Drug Misuse—are shared among VA and other agencies.

Several other government-wide high-risk areas also have direct implications for VA and its operations, including (1) Improving the Management of IT Acquisitions and Operations, (2) Strategic Human Capital Management, (3) Managing Federal Real Property, (4) Government-wide Personnel Security Clearance Process, and (5) Ensuring the Cybersecurity of the Nation. In particular, we encourage you to give attention to our recommendations related to strengthening the access controls and security configurations of VA's high-impact systems. Continued vigilance in this area is needed.[6]

We urge your attention to the two VA high-risk areas and to the other high-risk areas as they relate to VA. Progress on high-risk issues has been possible through the concerted actions and efforts of Congress, the Office of Management and Budget (OMB), and the leadership and staff in agencies, including within VA.

Copies of this report are being sent to the Director of OMB and appropriate congressional committees including the Committees on Appropriations, Budget, Homeland Security and Governmental Affairs, and Veterans' Affairs, United States Senate; and the Committees on Appropriations, Budget, Oversight and Reform, and Veterans' Affairs, House of Representatives. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

I appreciate VA's continued commitment to these important issues. If you have any questions or would like to discuss any of the issues outlined in this letter, please do not hesitate to contact me or A. Nicole Clowers, Managing Director, Health Care, at clowersa@gao.gov or 202-512-

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[5]GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021).

[6]This letter does not include priority recommendations related to strengthening the access controls and security configurations of VA's high-impact systems because the report that contained these recommendations is not publicly available.

7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Our teams will continue to coordinate with your staff on all of the 233 open recommendations. Thank you for your attention to these matters.

Sincerely yours,

Gene L. Dodaro

Comptroller General

of the United States

Enclosure – 1

cc: Mr. Thomas Murphy, Acting Under Secretary for Benefits, VBA

         Dr. Richard A. Stone, Acting Under Secretary for Health, VHA

         Mr. Jeffrey R. Mayo, Acting Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness, VA

         Mr. Harvey Johnson, Deputy Assistant Secretary for Resolution Management, Diversity, and Inclusion, VA

         Mr. Dominic Cussatt, Acting Assistant Secretary for Information and Technology and Chief Information Officer, VA

         Mr. Michael D. Parrish, Executive Director for Acquisitions, Logistics, and Construction, and Chief Acquisition Officer, VA

         Mr. Mark C. Probus, Director, VHA Medical Supply Program Office, VHA Procurement and Logistics Office, VHA

         Ms. Deborah E. Kramer, Acting Assistant Under Secretary for Health for Support, VHA

         Mr. Michael J. Missal, Inspector General, VA

         The Honorable Shalanda Young, Acting Director, OMB

Enclosure I Priority Open Recommendations to VA

Improving VA's Response to the Coronavirus Disease 2019 (COVID-19) Pandemic

> *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response.* **GAO-21-191.** **Washington, D.C.: November 30, 2020.**

Recommendation: The Department of Veterans Affairs (VA) Under Secretary for Health should collect timely data on COVID-19 cases and deaths in each state veterans home, which may include using data already collected by the Centers for Medicare & Medicaid Services.

Action Needed: VA agreed in principle with our recommendation. As of March 2021, VA was posting data on its website on COVID-19 cases and deaths among residents and staff for 130 of 158 state veterans homes. To fully implement this recommendation, VA needs to demonstrate that it is collecting data from each of the 158 state veterans homes.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Improving Oversight of Veterans' Access to Timely Health Care

> **VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement. GAO-13-130. Washington, D.C.: December 21, 2012.**

Recommendation: To ensure reliable measurement of veterans' wait times for medical appointments, we recommend that the Secretary of VA direct the Under Secretary for Health to take actions to improve the reliability of wait time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error.

Action Needed: VA agreed with our recommendation. The Veterans Health Administration (VHA) has taken actions intended to address the reliability of appointment wait times through improvements in appointment scheduling, including issuing a revised scheduling policy, providing and documenting scheduler training, and improving oversight through scheduler audits. While the revised scheduling policy and subsequent guidance changed the terminology of wait-time measures, they did not substantively clarify or define the desired date. Therefore, we continue to believe that the desired date field is still subject to interpretation and prone to scheduler error, which poses concerns for the reliability of wait times measured using patients' desired dates. Furthermore, VHA's first internal audit in February 2019 was unable to evaluate the accuracy and reliability of its wait-time data due to the lack of business rules for calculating them, indicating that additional efforts are needed to address this issue.

The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 requires VA to establish a process and requirements for scheduling appointments,

including the maximum number of days allowed to complete the scheduling process.[1] GAO is to report no later than January 5, 2023, on VHA's compliance with its new processes and requirements for appointment scheduling that are mandated in the same law. According to VHA officials, the department is in the process of implementing a new scheduling system (integral to its new electronic health record system), with a targeted national completion date of 2027 for implementation across all VA health care facilities. Given our continued concerns about VHA's ability to ensure the reliability of the wait-time data and the distant completion date of VA's new scheduling system, VHA should clarify its existing policy or provide additional details and documentation regarding how the new scheduling system will address these concerns and whether the new scheduling system will be adapted to accommodate the scheduling process and requirements under the recent law.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

> **Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities. GAO-19-462. Washington, D.C.: June 19, 2019.**

Recommendation: The Under Secretary for Health should establish a comprehensive policy that clearly defines Veterans Integrated Service Network (VISN) roles and responsibilities for managing and overseeing medical centers.

Action Needed: VA agreed in principle with our recommendation. To implement this recommendation, VHA will need to develop a policy—the type of document VHA requires when assigning responsibilities for executing a course of action to individuals or groups—that defines VISN roles and responsibilities for managing and overseeing medical centers.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Improving Oversight of the Veterans Community Care Program

> *VA Health Care: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans. GAO-17-52. Washington, D.C.: December 2, 2016.*

Recommendation: To improve care for women veterans, we recommend that the Secretary of VA direct the Under Secretary for Health to monitor women veterans' access to key sex-specific care services—mammography, maternity care, and gynecology—under current and future community care contracts. For those key services, monitoring should include an examination of appointment scheduling and completion times, driving times to appointments, and reasons appointments could not be scheduled with community providers.

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[1]Pub. L. No. 116-315, tit. III, § 3101, 134 Stat. 4932, 4999 (2020).

Action Needed: VA agreed with our recommendation. According to a March 2021 update, VA said it will be modifying its existing community care quality improvement plans in order to obtain actionable data on appointment timeliness for mammography, maternity care, and gynecology services and expects to complete this process by August 2021. To implement this recommendation, VHA needs to provide documentation that, as a part of its community care program, there is a monitoring plan (including time frames, data analyzed, and actions taken) to not only examine timely appointment scheduling and completion times for gynecology, maternity care, and mammography services, but also driving times to these appointments and reasons appointments could not be scheduled with community providers.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs. GAO-18-281. Washington, D.C.: June 4, 2018.

Recommendation: The Under Secretary for Health should establish an achievable wait-time goal for the consolidated community care program that VA plans to implement that will permit VHA to monitor whether veterans are receiving VA community care within time frames that are comparable to the amount of time they would otherwise wait to receive care at VHA medical facilities.

Recommendation: The Under Secretary for Health should design an appointment scheduling process for the consolidated community care program that VA plans to implement that sets forth time frames within which veterans' (1) referrals must be processed, (2) appointments must be scheduled, and (3) appointments must occur, which are consistent with the wait-time goal VHA has established for the program.

Action Needed: VA agreed with our recommendations initially, but in January 2021, the department stated it no longer plans to establish an overall wait-time performance measure for the Veterans Community Care Program, noting it does not have control over community providers' scheduling capabilities. GAO continues to believe developing an overall wait-time performance measure for the Veterans Community Care Program is important so that VA can evaluate the extent of timely access and identify any deficiencies in its appointment scheduling process or networks of community providers.

To fully implement these recommendations, VHA will need to take the following actions: (1) establish an overall wait-time performance measure for the Veterans Community Care Program; (2) design an appointment scheduling process for the program that is in keeping with the established wait-time performance measure that outlines time frames for completion of the various steps in the appointment scheduling process, such as when referrals must be processed, appointments scheduled, and veterans seen by the provider; (3) measure the timeliness of veterans seen in VHA medical facilities and by community care providers; and (4) determine if veterans are receiving community care within time frames that are comparable to the amount of time they would wait to receive care at VA medical facilities.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

> ***Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care.* GAO-20-643. Washington, D.C.: September 28, 2020.**

Recommendation: The Under Secretary of Health should align its monitoring metrics with the time frames established in the Veterans Community Care Program scheduling process.

Action Needed: As of April 2021, VA continues to disagree with the recommendation. Although VA responded to our report by stating that the department already monitors key steps in the Veterans Community Care Program scheduling process that align with policy, we continue to believe this recommendation is valid for two reasons. First, VA's response did not address an issue we found for one of the metrics it monitors, which is that the metric is inconsistent with the guidance it asks staff to follow when reviewing a referral. Second, VA has not yet established time frames to account for the entire Veterans Community Care Program appointment scheduling process, and therefore, is unable to align any of its metrics to achieve a yet-established goal. To implement this recommendation, VA needs to review, and if needed, update the time frames in its Veterans Community Care Program scheduling process, and then align its monitoring metrics accordingly.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Improving Management of Human Capital

> **Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges. GAO-17-30. Washington, D.C.: December 23, 2016.**

Recommendation: To accelerate efforts to develop a modern, credible, and effective performance management system, the Assistant Secretary for Human Resources and Administration, with input from VHA stakeholders, should ensure that meaningful distinctions are being made in employee performance ratings by (1) developing and implementing a standardized, comprehensive performance management training program for supervisors of Title 5, Title 38, and Title 38-Hybrid employees based on leading practices, and ensuring procedures are in place to support effective performance conversations between supervisors and employees; (2) reviewing and revising Title 5 and Title 38 performance management policies consistent with leading practices (e.g., require definition of all performance levels); and (3) developing and implementing a process to standardize performance plan elements, standards, and metrics for common positions across VHA that are covered under VA's Title 5 performance management system.

Action Needed: VA partially agreed with our recommendation. VA has taken important steps towards addressing this recommendation. Specifically, in May 2020, VA implemented an enterprise-wide performance management system that features department-wide training, covering employees under Title 5, Title 38, and Title 38-Hybrid. VA also revised its performance

management policy for Title 5, Title 38, and Title 38-Hybrid positions; however, VA has not yet implemented the policy. To fully implement the recommendation, VA needs to develop and implement a process to standardize performance plan elements, standards, and metrics for common positions across VHA. VA estimated doing so in the fourth quarter of fiscal year 2021.

High Risk Area: Managing Risks and Improving VA Health Care

Acting Director: Alissa Czyz, Strategic Issues

Contact information: czyza@gao.gov, (202) 512-6806

> **Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. GAO-18-124. Washington, D.C.: October 19, 2017.**

Recommendation: The Under Secretary for Health should develop and implement a process to accurately count all physicians providing care at each medical center, including physicians who are not employed by VHA.

Action Needed: As of March 2021, VA continues to disagree with the recommendation. Although VA responded to our report by stating that the ability to count physicians does not affect its ability to assess workload, we continue to believe that VHA needs a systematic process that is available at the local level to identify all physicians working at VA medical centers as part of the agency's efforts to monitor and assess workload. To implement the recommendation, VHA needs to develop a system-wide process to collect workload information on all physicians providing care at VA medical centers, including physicians who are not employed by VHA. This information should be available at the local level for workforce planning purposes.

High Risk Area: Managing Risks and Improving VA Health Care, Strategic Human Capital Management

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

> **Department of Veterans Affairs: Improved Succession Planning Would Help Address Long-Standing Workforce Problems. GAO-20-15. Washington, D.C.: October 10, 2019.**

Recommendation: The Secretary of Veterans Affairs should develop a department-wide succession plan for leadership and mission-critical occupations that incorporates key leading practices for succession planning.

Action Needed: VA concurred with our recommendation. To implement this recommendation, VA needs to develop a succession plan for its leadership positions as well as for occupations identified as mission-critical. In January 2021, VA officials reported that they expect to issue the plan by the summer of 2021.

High Risk Area: Strategic Human Capital Management

Acting Director: Alissa Czyz, Strategic Issues

Contact information: czyza@gao.gov, (202) 512-6806

> **Sexual Harassment: Inconsistent and Incomplete Policies and Information Hinder VA's Efforts to Protect Employees. GAO-20-387. Washington, D.C.: June 15, 2020.**

Recommendation: VA's Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness should realign VA's Equal Employment Opportunity (EEO) Director position to adhere to the applicable Equal Employment Opportunity Commission (EEOC) directive by ensuring the position is not responsible for personnel functions.

Action Needed: VA did not agree with our recommendation. Nevertheless, in September 2020, VA met with the EEOC to discuss, among other things, alignment of VA's EEO Director position. VA plans to continue to work with EEOC to assess the alignment of this position. To implement our recommendation VA needs to make changes to the EEO Director position, in accordance with the EEOC directive.

Recommendation: VA's Deputy Assistant Secretary for Resolution Management should complete VA's EEO Program Manager realignment initiative at the Veterans Benefits Administration (VBA) and VHA in accordance with VA policy.

Action Needed: VA agreed with our recommendation. VA completed its EEO Program Manager realignment at VBA in early 2021. However, to implement our recommendation VA needs to complete the realignment of EEO Program Managers at VHA. VA is developing a plan to address the realignment of EEO Program Managers at VHA, which is projected to start in fiscal year 2024.

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Improving Management of Information Technology

> ***Data Center Optimization: Additional Agency Actions Needed to Meet OMB Goals.
> GAO-19-241. Washington, D.C.: April 11, 2019.***

Recommendation: The Secretary of VA should take action to meet the data center optimization metric targets established under the Data Center Optimization Initiative by the Office of Management and Budget (OMB).

Action Needed: VA agreed with our recommendation. As of December 2020, the department reported that it had met its fiscal year 2020 targets for two of the four data center optimization metrics tracked by OMB. However, we continue to believe that full implementation of this recommendation will require steps beyond what the department is currently reporting. Specifically, to fully implement this recommendation, VA will need to meet all four of OMB's metrics.

High Risk Area: Improving the Management of IT Acquisitions and Operations

Director: Carol C. Harris, Information Technology and Cybersecurity

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Data Protection: Federal Agencies Need to Strengthen Online Identity Verification Processes. GAO-19-288. Washington, D.C.: May 17, 2019.

Recommendation: The Secretary of the Department of Veterans Affairs should develop a plan with time frames and milestones to discontinue knowledge-based verification, such as by using Login.gov or other alternative verification techniques.

Action Needed: VA agreed with our recommendation. VA has developed a plan that eliminated some uses of knowledge-based verification, bringing the agency closer to full implementation. However, to fully implement this recommendation, VA's plan needs to fully address elimination of knowledge-based verification.

High Risk Area: Ensuring the Cybersecurity of the Nation

Director: Jennifer R. Franks, Information Technology and Cybersecurity

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> **Cybersecurity: Agencies Need to Fully Establish Risk Management Programs and Address Challenges. GAO-19-384. Washington, D.C.: July 25, 2019.**

Recommendation: The Secretary of VA should develop a cybersecurity risk management strategy that includes the key elements identified in this report.

Action Needed: VA agreed with our recommendation. VA has indicated that it is working to develop a cybersecurity risk-management strategy as part of a comprehensive risk management program plan. As of March 2021, VA had not provided evidence that it had completed these efforts. To implement this recommendation, VA needs to ensure that its strategy addresses key elements identified in our report, including having a statement of risk tolerance and how the agency intends to assess, respond to, and monitor cybersecurity risks.

Recommendation: The Secretary of VA should establish a process for conducting an organization-wide cybersecurity risk assessment.

Action Needed: VA agreed with our recommendation and indicated that it is working to establish a process for an organization-wide cybersecurity risk assessment as part of a comprehensive risk-management program plan. As of March 2021, VA had not provided evidence that it had completed these efforts. To implement this recommendation, VA will need to ensure that it has established a process for aggregating and assessing cyber-related risks from across its organization.

High Risk Area: Ensuring the Cybersecurity of the Nation

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Improving Appeals Reform for Disability Benefits

***VA Disability Benefits: Improved Planning Practices Would Better Ensure Successful Appeals Reform*. GAO-18-352. Washington, D.C.: March 22, 2018.**

Recommendation: The Secretary of VA should clearly articulate in VA's appeals plan how VA will monitor and assess the new appeals process compared to the legacy process, including specifying a balanced set of goals and measures—such as timeliness goals for all the VBA appeals options and the Board of Veterans' Appeals (Board) dockets, and measures of accuracy, veteran satisfaction, and cost—and related baseline data.

Action Needed: VA initially agreed with our recommendation, but as of April 2021, VA has changed its position and now partially agrees. Specifically, VA has reported certain performance metrics for the new and legacy appeals processes and is working to track and report on complete metrics for timeliness, accuracy, and veterans' satisfaction, which can be used to monitor and assess the new appeals process against the legacy process. However, VA officials said they no longer agreed with the need to compare the legacy and new appeals processes. They stated that the new process is timelier than the legacy process, while also stating that comparing the two processes would be too difficult and would provide no value.

We continue to believe that developing a methodology and assessing the relative efficacy of the new process is important to understand whether the new process is an improvement and meets veterans' needs. To fully implement our recommendation, VA needs to establish (1) a balanced set of performance goals and measures for all new appeals options, including overall timeliness, accuracy, and veterans' satisfaction, as well as (2) a methodology for how it will assess how well the new process is performing relative to the legacy process.

Recommendation: The Secretary of VA should ensure that the appeals plan more fully addresses risk associated with appeals reform—for example, by assessing risks against a balanced set of goals and measures, articulating success criteria and an assessment plan for the Rapid Appeals Modernization Program (RAMP), and testing or conducting sensitivity analyses of all appeal options—prior to fully implementing the new appeals process.

Action Needed: VA agreed with our recommendation and took several steps to identify risks prior to implementing its new disability appeals process. Moreover, many of the principles of sound planning practices that informed our recommendation remain relevant, even after implementation. VA needs to continue applying these principles to better address risks associated with implementing the new process. For example, the Board's new hearing option, which is the most resource intensive of several appeals options, accounted for over 60 percent of the new appeals inventory as VA continues to prioritize other workloads and address COVID-19-related slowdowns in hearings. To fully implement our recommendation, VA will need to articulate key goals and measures, such as accuracy and timeliness of decisions or veterans' satisfaction, to create a balanced set of measures that would more fully inform VA's assessment of risk.

High Risk Area: Improving and Modernizing Federal Disability Programs

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Ensuring Safe, High-Quality Care for Veterans

> **Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care. GAO-19-6. Washington, D.C.: February 28, 2019.**

Recommendation: The Under Secretary for Health should develop policies and guidance regarding Drug Enforcement Administration (DEA) registrations, including the circumstances in which DEA waivers may be required, the process for requesting them, and a mechanism to ensure that facilities follow these policies.

Action Needed: VA agreed with our recommendation. VA sent a letter to the DEA asking for clarification about DEA employment waivers and received a response from the DEA dated November 26, 2019. VA officials told us that they are considering the input from the DEA and consulting with relevant stakeholders to determine next steps. However, to fully implement this recommendation, VA needs to provide evidence of actions taken to ensure that DEA requirements regarding DEA registrations and employment waivers are met. Such actions include developing policies regarding when a DEA employment waiver may be necessary and guidance about how to request such a waiver. VA officials told us that their target completion date for implementing this recommendation is June 2021.

High Risk Area: Managing Risks and Improving VA Health Care

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Improving VA's Efforts to Prevent Veteran Suicides

> ***Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*. GAO-20-664. Washington, D.C.: September 9, 2020.**

Recommendation: The Under Secretary for Health should, in collaboration with relevant VBA and National Cemetery Administration (NCA) officials, improve its process to accurately identify all on-campus veteran deaths by suicide by ensuring that it uses updated information and corroborates information with VA facility officials.

Action Needed: VA agreed with our recommendation and stated that it established a standing committee that includes representatives from VHA, VBA, NCA, and the VA Office of Operations, Security, and Preparedness. VA also told us that the committee began meeting on a monthly basis in October 2020, and that the committee will provide actionable recommendations to improve processes for accurately identifying on-campus veteran deaths by suicide by July 2021. However, to fully implement this recommendation, VHA needs to complete development of its process to collect accurate data for on-campus veteran deaths by suicide and ensure that it uses updated information and corroborates information with all VA facilities

Recommendation: The Under Secretary for Health should expand the policy requirement for a root cause analysis to include all cases of on-campus veteran death by suicide, regardless of whether the veterans involved were enrolled in VHA health care services at the time of their death.

Action Needed: As of March 2021, VA continues to disagree with this recommendation. Although VA responded to our report by stating that a root cause analysis was not the appropriate tool for conducting suicide surveillance for all cases and that a committee would identify methods for expanding existing VHA reporting to include VBA and NCA, we continue to believe that VA should perform a root cause analysis because it is an existing process that could easily be expanded to examine all on-campus veteran suicides. To implement this recommendation, VHA needs to ensure that, for all on-campus deaths by suicide, its yet-to-be established process captures the elements found in a root cause analysis—such as what happened, why it happened, and if it could be prevented in the future.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

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Ensuring Efficiency within the VA Health Care System

Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding. GAO-19-670. Washington, D.C.: September 23, 2019.

Recommendation: The VA Under Secretary of Health should revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels. These approaches could include adjusting the level of services offered.

Action Needed: VA agreed in principle with our recommendation. VHA stated that it is conducting market assessments over a multi-year period to increase access and quality of care to veterans. VHA said that after completing the market assessments and reviewing information from other VHA efforts, it may consider adjusting the level of services along with other alternatives. VHA expects to complete these actions by January 2022. However, to fully implement our recommendation, VHA needs to demonstrate it has taken these actions and revised its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workloads that received adjusted funding levels.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Sharon M. Silas, Health Care

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Improving Management of National Policy Documents

Veterans Health Care: Additional Actions Could Further Improve Policy Management. GAO-17-748. Washington, D.C.: September 22, 2017.

Recommendation: The Under Secretary for Health should further clarify when and for what purposes each national policy and guidance document type should be used, including whether guidance documents, such as program office memos, should be vetted and recertified.

Action Needed: VA agreed with our recommendation. VHA issued a November 2019 interim policy clarifying the use of national policy and guidance documents, and an October 2019 interim policy describing vetting and recertification requirements for operational memos. However, VHA interim policy, by definition, is automatically rescinded after 1 year unless incorporated into a national policy directive. As a result, VHA recertified these interim policies in October 2020, and stated that it plans to continue doing so until its national policy directive is updated. To fully implement our recommendation, VHA needs to provide us with the finalized version of its recertified national policy directive.

High Risk Area: Managing Risks and Improving VA Health Care

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Improving Management of Procurement Policies and Practices

> ***Veterans Affairs Contracting: Improvements in Policies and Processes Could Yield Cost Savings and Efficiency. GAO-16-810. Washington, D.C.: September 16, 2016.***

Recommendation: In order to ensure that contracting officers have clear and effective policies as soon as possible, the Secretary of VA should direct the Office of Acquisition and Logistics to identify measures to expedite the revision of the Veterans Affairs Acquisition Regulation, which has been ongoing for many years, and the issuance of the VA Acquisition Manual.

Action Needed: VA agreed with our recommendation. To implement this recommendation, VA needs to expedite the issuance of its revised VA Acquisition Regulation, as well as the companion VA Acquisition Manual to ensure its workforce has clear and effective policies. As of April 2021, VA issued 32 proposed or final rules with the remaining 9 expected to be published as draft rules by September 2021.

High Risk Area: VA Acquisition Management

Director: Shelby Oakley, Contracting and National Security Acquisitions

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> **Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency. GAO-18-34. Washington, D.C.: November 9, 2017.**

Recommendation: The Director of the Medical Surgical Prime Vendor-Next Generation program office should, with input from the Strategic Acquisition Center, develop, document, and communicate to stakeholders an overarching strategy for the program, including how the program office will prioritize categories of supplies for future phases of requirement development and contracting.

Action Needed: VA agreed with our recommendation. VA planned to implement a new Medical Surgical Prime Vendor (MSPV) program, called MSPV 2.0, by March 2020. However, as of March 2021, VA stated that this program is delayed until October 2021. Further, there are currently a number of uncertainties in VA's MSPV program, including VA's stated intent to

switch to the Defense Logistics Agency's MSPV program, and the pause in VA's clinician-driven strategic sourcing effort due to the COVID-19 pandemic. To implement our recommendation, VA needs to develop an overarching strategy for its MSPV program that clearly explains its plans to users and other stakeholders.

High Risk Area: VA Acquisition Management

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> ***VA Acquisition Management: Steps Needed to Ensure Healthcare Federal Supply Schedules Remain Useful. GAO-20-132. Washington, D.C.: January 9, 2020.***

Recommendation: The Secretary of Veterans Affairs should take steps to assess duplication between VA's Federal Supply Schedules (FSS) and MSPV programs, to determine if this duplication is necessary or if efficiencies can be gained.

Action Needed: VA agreed with our recommendation. To implement this recommendation, VA needs to complete its assessment of whether duplication across its VA FSS and MSPV programs is necessary and efficient. In February 2021, VA completed a report on its agency-wide Category Management efforts that it sees as an initial step in this process, but VA has yet to assess the duplication between VA FSS and MSPV.

High Risk Area: VA Acquisition Management

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> **VA Acquisition Management: Comprehensive Supply Chain Management Strategy Key to Address Existing Challenges. GAO-21-445T. Washington, D.C.: March 24, 2021.**

Recommendation: The Secretary of Veterans Affairs should ensure the VHA Assistant Under Secretary for Health for Support develops a comprehensive supply chain management strategy that outlines how VHA's various supply chain initiatives are related to each other and to VA-wide initiatives. This strategy should link to VA's overall plans to address its broader acquisition management challenges and reflect key practices of organizational transformations, including an implementation plan with key milestones.

Action Needed: VA officials expressed verbal agreement with this recommendation. To implement it, VA needs to develop a comprehensive supply chain management strategy that addresses the interrelationships between its various modernization relationships, and reflects key practices of organizational transformations, including an implementation plan with key milestones.

High Risk Area: VA Acquisition Management

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Improving VA's Capital Planning

   VA Real Property: Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations. GAO-19-440. Washington, D.C.: June 13, 2019.

Recommendation: To improve VA's ability to plan for and align its facilities with estimated changes to veterans' needs and expectations, we recommend that the Secretary of Veterans Affairs ensure the appropriate offices and administrations instruct VA medical centers on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as by identifying certain resources or tools and directing VA medical centers to use them.

Action Needed: VA agreed with the recommendation and indicated that it would instruct users on what data to use in planning and updates, which would help ensure veterans' input is incorporated where appropriate. As part of that effort, in January 2020 VA issued guidance to VA medical centers. In particular, this guidance instructed users how to ensure that planning is consistent with veterans' needs. However, to fully implement our recommendation, VA needs to provide guidance to instruct the VA medical centers how to ensure that this planning is also consistent with veterans' changing expectations.

High Risk Area: Managing Risks and Improving VA Health Care

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